



Joint Commission on Health Care

Thursday, November 14, 2019 – 9:00 a.m.

Senate Committee Room A- Pocahontas Building

Members Present

Delegate David L Bulova	Senator Charles W. Carrico, Sr.
Delegate T. Scott Garrett	Senator Rosalyn R. Dance
Delegate Patrick A. Hope	Senator Siobhan S. Dunnavant
Delegate Riley E. Ingram	Senator John S. Edwards
Delegate Kaye Kory	Senator L. Louise Lucas
Delegate Christopher K. Peace	Senator Glenn H. Sturtevant, Jr.
Delegate Christopher P. Stolle	Senator David R. Suetterlein

Members Absent

Delegate C.E “Cliff” Hayes, Jr.
Delegate Roslyn C. Tyler
Senator George L. Barker
Honorable Daniel Carey, M.D.

Staff Present

Michele Chesser
Andrew Mitchell
Stephen Weiss
Agnes Dymora

Paula Margolis- called in

Call to order- Senator Dance

Executive Director, Michele Chesser, provided comments to the members who will be departing the commission this year.

The Decision Matrix was presented by each JCHC staff and members voted on policy options.

Language Development Milestones and Parent Resources for Young Deaf/Hard of Hearing Children

Option 1. Take no action. Approved by 13-0 vote

Increased Prescription Delivery Options at Same Cost for Health Plan Members

Option 1. Take no action. Approved by 10-3 vote

Naloxone Public Access & Storage

Option 1 Failed by 4-9 vote

Option 2 Approved by 9-4 vote

Introduce legislation to amend §54.1-3408 by adding language authorizing persons acting on behalf of public places, who have completed a training program, to possess and administer intranasal / intramuscular formulations of naloxone in case of suspected overdose. For this section, “public place” is defined as any enclosed location that is used or held out for use by the public, whether owned or operated by public or private interests, and is regularly staffed.

Option 3 Approved by 9-4 vote

Introduce legislation broadening criminal and civil liability protections for naloxone administration. Suggested language: A person who is 1) not otherwise authorized to administer naloxone or other opioid antagonist used for overdose reversal and 2) acting in good faith, and in the absence of gross negligence or willful and wanton misconduct, may administer an opioid antagonist to another person who appears to be experiencing an opioid related drug overdose. The person administering naloxone or other opioid antagonist used for overdose reversal shall not be considered to be engaged in the unauthorized practice of medicine or the unlawful possession of an opioid antagonist. A person who administers an opioid antagonist pursuant to this article is personally immune from civil or criminal liability for any act or omission resulting in damage or injury. [Note: language developed with input from representatives of the Virginia Association of Commonwealth's Attorney, Virginia Criminal Justice Conference, and Virginia Trial Lawyers Association]

Option 4 Approved by 9-4 vote

By letter of the JCHC Chair, request that the Board of Pharmacy include information about Virginia laws making naloxone available without a patient-specific prescription in the next pharmacy profession license renewal communication

Option 5 Approved by 10-3 vote

By letter of the JCHC Chair, request that the HHR Secretary convene a task force to study current roles of Public Safety Answering Points (911 call centers) and regional Poison Control Centers in providing information/assistance to the public on opioid overdoses and naloxone in both acute and non-acute situations. A written report – submitted to the JCHC by October 31, 2020 – should provide recommendations on any necessary enabling legislation or funding that may be required to enhance their respective roles

Forensic Nursing in the Commonwealth

Option 3 Amended failed by 6-6 vote

Option 4 Amended approved by 7-6 vote

Introduce legislation to amend § 15.2-1627.4 of the Code of Virginia by adding the following. In addition, the attorney for the Commonwealth shall invite other individuals, or their designees, including: local health department district directors; hospital administrators from each licensed hospital within the jurisdiction; safety-net provider clinic directors from each clinic within the jurisdiction (including those created by 42 CFR 491.1 and the free and charitable clinics); and any other local health care providers to participate in the annual meeting. Attendance shall be encouraged but is not required. Attorneys for the Commonwealth are authorized to conduct the sexual assault response team annual meetings using other methods to encourage attendance, including conference telephone calls and videoconferencing as provided by Title 2.2 (§ 2.2-3708.2) Chapter 37.

Option 5 Approved by 13-0 vote

Introduce legislation to amend the Code of Virginia to allow victims of sexual assault to access victim funds for all medical expenses regardless of whether a victim chooses to report a sexual assault to law enforcement or chooses to have an exam without a PERK.

Option 6 Approved by 13-0 vote

Introduce legislation to amend the Code of Virginia to require the Bureau of Insurance to establish regulations, and the Department of Medical Assistance Services to require in its contracts with managed care companies, that covered individuals and members receiving health services can choose a preferred method of receiving the explanation of benefits form from their insurer as permitted by 45 CFR § 164.522; restrict information contained in the EOB if it contains a description of sensitive services. Authorize the Bureau of Insurance to define sensitive health care services; consulting with experts on infectious disease, reproductive and sexual health, domestic violence and sexual assault, mental health, and substance use disorders.

Option 8 Amended approved by 13-0 vote

Introduce a budget amendment, amount to be determined, if any, creating an Implementation Work Group (IWG) led by the Office of the Secretary of Health and Human Resources to determine the feasibility of transferring the SAFE program and all related claims for medical expenses related to sexual assault, strangulation, domestic/intimate partner violence, human trafficking, and adult or child abuse from the Virginia Workers Compensation Board to the Department of Medical Assistance Services. The Implementation Work Group should also include members from the Office of the Attorney General, the Office of the Secretary of Public Safety and Homeland Security, the Office of the Executive Secretary of the Supreme Court, the Workers Compensation Commission, Department of Medical Assistance Services, Department of Criminal Justice Services, and Department of Planning and Budget. The IWG shall make a recommendation regarding whether to increase reimbursement

rates for sexual assault examinations to the actual costs of the exams and to include reimbursements for the costs associated with preparing for, and appearing in, court when a forensic nurse is subpoenaed during a trial. If not feasible to move to DMAS, the work group shall create an efficient, seamless electronic medical claim processing system for hospitals and health care providers that coordinates payments from all fund sources, suppresses EOBs and removes patient from the medical billing and reimbursement process. The Implementation Work Group shall present a report with any necessary statutory changes and budget requirements to the Governor, the Chairman of the House Appropriations Committee, the Senate Finance Committee, and to the Joint Commission on Health Care by September 1, 2020, for consideration in the Executive Budget for SFY-2021.

Supported Decision Making for Individuals with Intellectual and Developmental Disabilities

Option 3 Approved by 10-1 vote

Introduce legislation to add a new section to the VA Code, Title 37.2 (Behavioral Health and Developmental Services) and/or Title 59.1 (Trade and Commerce) creating SDM for Individuals with Developmental Disabilities and/or all disabled adults as an option for DBHDS and to formalize a supported decision making contract in code that provides protections for private individuals that want to use a contract (e.g. use Delaware law as model: 80 Del. Laws, c. 427; Code § 9401A, et. seq.).

Option 4 Approved by 12-0 vote

Introduce legislation to amend VA Code § 64.2-2003.C. by adding a requirement that guardian ad litem consider whether supported decision making is a viable option when reviewing and reporting on the extent of the duties and powers of the guardian or conservator.

Option 7 Amended approved by 12-0 vote

Introduce ~~a Section 1 bill~~ **legislation** directing VDOE to update special education transition materials for students and parents; directing school divisions to use the VDOE material to the fullest extent possible and include more information about transition for students and parents during the annual IEP meetings related to health care and other options available, including supported decision making.

Option 8 Approved by 8-3 vote

Introduce legislation to amend VA Code § 64.2-2003 to include a requirement that a person's IEP be part of the GAL's review and report for those between 17.5 through 21 years of age.

Option 9 Approved by 12-0 vote

Introduce legislation to amend VA Code § 64.2-2000, et. seq. to clarify the code sections as follows:

§ 64.2-2000, definitions should be more complete so prospective guardians, family members and others are aware of what is included in the Code. Definitions should be added for:

- * annual reports required by § 64.2-2020 (to indicate oversight)
- * guardian ad litem required by § 64.2-2003 (to clearly identify who will review and report to the judge at the hearing)
- * temporary guardian and conservator (clearly defined options to pursue, ask questions about)
- * power of attorney(s) to inform (clearly defined options to pursue, ask questions about)
- * Individual Education Plan (20 U.S. Code § 1414) that should be reviewed by guardian ad litem for persons between the ages of 17.5 through 21

Code clarifications:

- * the advanced directive reference in the definition section currently refers to the short title of the health care decisions act and not to the definition of advanced directive, the reference should be directed to the actual definition in § 54.1-2982
- * “Guardian” definition should include a reference to the duties and powers section § 64.2-2019 of a guardian
- * § 64.2-2007.C. related on the petition hearing should include a reference to § 64.2-2019.E. to make it clear that, to the extent feasible, the respondent (the subject of the hearing) will be encouraged to participate in decisions, act on his or her own behalf, and to develop or maintain the capacity to manage personal affairs if the respondent retains any decision-making rights

Option 10 Approved by 12-0 vote

Introduce legislation to amend VA Code § 64.2-2007 by adding a requirement that the following language be included in all guardianship orders:

- * Clearly state whether the order is a full order removing all rights, a limited order and what rights are removed from the respondent {incapacitated person}, and/or a temporary order indicating the time-frame that the order is in effect for.
- * A guardian, to the extent possible, should encourage the incapacitated person to participate in decisions, consider the expressed desires and personal values of the incapacitated person to the extent known, shall not unreasonably restrict an incapacitated person's ability to communicate with, visit, or interact with other persons with whom the incapacitated person has an established relationship pursuant to VA Code § 64.2-2019. E.
- * Annual reports should be filed by the guardian with the local department of social services for the jurisdiction where the incapacitated person then resides pursuant to VA Code § 64.2-2020.

- * Guardianship orders are subject to petition for restoration, modification, or termination pursuant to the provisions VA Code § 64.2-2012.

Dispensing of Drugs and Devices Pursuant to Pharmacy Collaborative Practice Agreements, Standing Orders and Statewide Protocols

Option 4 Amended approved by 11-0 vote

~~Add independent practice nurse practitioners and physician assistants to the list of practitioners that can be party to a CPA with a pharmacist.~~

Introduce legislation to amend the definition of “collaborative agreement” in § 54.1-3300 to read: "Collaborative agreement" means a voluntary, written, or electronic arrangement between one pharmacist and his designated alternate pharmacists involved directly in patient care at a single physical location where patients receive services and (i) any person licensed to practice medicine, osteopathy, or podiatry together with any person licensed, registered, or certified by a health regulatory board of the Department of Health Professions who provides health care services to patients of such person licensed to practice medicine, osteopathy, or podiatry; (ii) a physician's office as defined in § 32.1-276.3, provided that such collaborative agreement is signed by each physician participating in the collaborative practice agreement; (iii) any licensed physician assistant working under the supervision of a person licensed to practice medicine, osteopathy, or podiatry; or (iv) any licensed nurse practitioner working in accordance with the provisions of § 54.1-2957 including a licensed independent nurse practitioner, involved directly in patient care which authorizes cooperative procedures with respect to patients of such practitioners. Collaborative procedures shall be related to treatment using drug therapy, laboratory tests, or medical devices, under defined conditions or limitations, for the purpose of improving patient outcomes. A collaborative agreement is not required for the management of patients of an inpatient facility.

and Amend § 54.1-3300.1 to read: (i) any person licensed to practice medicine, osteopathy, or podiatry together with any person licensed, registered, or certified by a health regulatory board of the Department of Health Professions who provides health care services to patients of such person licensed to practice medicine, osteopathy, or podiatry; (ii) a physician's office as defined in § 32.1-276.3, provided that such collaborative agreement is signed by each physician participating in the collaborative practice agreement; (iii) any licensed physician assistant working under the supervision of a person licensed to practice medicine, osteopathy, or podiatry; or (iv) any licensed nurse practitioner working in accordance with the provisions of § 54.1-2957 including a licensed independent nurse practitioner, involved directly in patient care which authorize cooperative procedures related to treatment using drug therapy, laboratory tests, or medical devices, under defined conditions or limitations, for the purpose of improving patient outcomes. However, no person licensed to practice

medicine, osteopathy, or podiatry, and licensed independent nurse practitioners shall be required to participate in a collaborative agreement with a pharmacist and his designated alternate pharmacists, regardless of whether a professional business entity on behalf of which the person is authorized to act enters into a collaborative agreement with a pharmacist and his designated alternate pharmacists.

Option 7 Approved by 11-0 vote

By letter from the JCHC Chair, request that the Boards of Pharmacy and Medicine convene a workgroup of expert stakeholders to determine if statewide standing orders can be expanded to other conditions (e.g., those for which there are CLIA Waived tests).

Prescription Drug Price Gouging

Option 1. Take no action. Approved by 6-3 vote

Option 2, 3, 4, 7, 8 Failed by 8-2 vote

This was a Non-Electronic Meeting:

Prepared by: Agnes Dymora